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Appendix 1: Glossary

Accessible services – are services that are affordable, located nearby, open during evenings and weekends, sensitive to individual and cultural values, and can handle consumer demand without placing people on a long waiting list.

Acute - in relation to an illness, means arising suddenly with intense severity of relatively short duration.

Adjustment disorders – are characterized by inappropriate or inadequate adjustments to a life stressor; the symptoms may be similar to the symptoms of other mental disorders, including depression, anxiety, and/or behavioral symptoms.

Advance directives - set out a patient's wishes in writing concerning their care or treatment.

Advice - means recommending what to do.

Advocacy - promotes the cause of another person to secure the services they require and their rights.

Advocacy groups – are organizations that work in a variety of ways to create change with issues that affect society. (NAMI is an example.)

Affective - means related to or resulting from the emotions.

Affective disorders - are a class of disorders characterized by disturbances in mood or the emotions; also called *mood disorders*; includes *bipolar disorder*, *cyclothymia*, *depression*, *dysthymia* .

Aggressive behavior - is verbal and/or physical actions or serious intentions, the consequences of which are likely to cause actual damage and/or distress.

Agoraphobia – is often related to *panic disorder* and is characterized by a fear of being in situations that might provoke a *panic attack*, or from which escape might be difficult if one occurred.

Alcohol abuse - means a pattern of alcohol use leading to significant impairment or distress; see also *substance abuse* and *substance dependence*.

Alzheimer's disease - is progressive dementia caused by destruction of brain cells. It usually occurs later in life.

Amnesia – means temporary or permanent loss of memory.

Anorexia nervosa - is an eating disorder characterized by refusal to eat or eating too little to meet ones daily caloric needs.

Antipsychotics - are a group of medications used to treat psychotic illnesses.

Anti-social personality disorder – is a personality disorder characterized by chronic antisocial behavior and violation of the law and the rights of others; see also *personality disorders*.

Anxiety disorders – are a class of disorders characterized by abnormal or inappropriate anxiety; includes *panic disorder, agoraphobia, specific phobias, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, and generalized anxiety disorder*.

Apathy – is a lack of emotion or interest in things one would ordinarily consider important; it is a symptom of several mental illnesses.

Appeal process — is a series of steps you must follow to get a decision about services reviewed and changed.

Assertive outreach - is an approach to engaging with individuals with a severe mental illness who may be difficult to reach; it involves providing services in the community that are accessible 24 hours a day and visits to service users in their own homes.

Assessment - is the gathering and appraisal of information in order to identify a person's needs and strengths.

Atypical antipsychotic medications – are newer medications used to treat symptoms of psychosis. They are chemically different from previous medications used and are thought to be less likely to cause involuntary movement side effects.

Autonomy – means to be self-governing.

Best practices – are activities or programs that are in keeping with the best available evidence regarding what is effective.

Bipolar disorder – is a serious affective disorder, typically beginning in adolescence or early adulthood, in which dramatic swings between manic “highs” and depressed “lows” alternate with periods of normal mood; also called *manic depression*.

Bulimia nervosa - is an eating disorder characterized by eating binges followed by purging (vomiting, using laxatives, etc.)

Case manager – is the health care professional who works directly with consumer or children and their families to coordinate various activities, services and supports, and acts as the consumer’s primary contact with other members of their treatment teams; also called *rehabilitation specialist, service coordinator, social worker*.

Case management – is a service that helps people arrange for *appropriate services* and supports. A *case manager* coordinates mental health, social work, educational, health, vocational, transportation, advocacy, *respite care*, and recreational services, as needed.

Child protective services – is a service designed to safeguard a child when abuse, neglect, or abandonment is suspected, or when there is no family to take care of the child. Help delivered in the home include financial assistance, vocational training, homemaker services, and daycare. If in-home supports are insufficient, the child may be removed from the home on a temporary or permanent basis.

Chronic - in relation to an illness, means developing slowly or of long duration.

Client – is a term often used by service providers for an individual who receives mental health services; see also *consumer*.

Clinical psychologist – is a mental health professional with highly specialized training in the diagnosis and psychological treatment of mental illness.

Clinical team – is a multi-disciplinary team of mental health professionals under the leadership of a clinical supervisor.

Clubhouse - is derived from the Fountain House model of psychiatric rehabilitation; it is a club that belongs to everyone who participates in it, providing supportive companionship and opportunities for employment.

Cognitive/cognition – means the general ability to organize, process, and recall information.

Cognitive behavioral therapy (CBT) - is a talking treatment designed to ease stress from emotional problems; it addresses personal beliefs which may result in negative emotional responses, concentrating on understanding behavior rather than the actual cause of a problem.

Cognitive disability - is where a person experiences a loss of functioning that causes difficulties for them in undertaking basic activities of daily living.

Cognitive disorders – are a class of disorders characterized by significant negative changes in the way a person thinks and/or remembers; includes *delirium, dementia, amnesia, etc.*

Collaboration - is where professionals and/or agencies with linked functions work effectively together on common issues, including the provision of care to an individual person.

Community – is a group of people residing in the same locality or sharing a common interest.

Community care - is the provision of services and support for people who are affected by a range of problems, including mental illness, to enable them to live as independently as possible in their own homes or in other home-like settings.

Community mental health agencies (CMHAs) – are groups of professionals providing mental health services for a locality.

Comorbidity – is the occurrence of two or more disorders at the same time; see also *co-occurring disorder, dual diagnosis*.

Compulsive behavior/compulsions – means performing repetitive and often senseless acts, often in response to an *obsession*; see also *obsessive compulsive disorder*.

Confidentiality – is the protection and proper use of patient information. Information given or received for one purpose may not be used for a different purpose or passed to anyone else without the consent of the provider of the information.

Consumer - is a term to describe someone who uses or has used mental health services because of mental illness or a disability; within service provider organizations, also called a *client*.

Continuum of care – is a term that implies a progression of services that a consumer or child moves through, usually one service at a time. More recently, it has come to mean comprehensive services. Also see *system of care* and *wraparound services*.

Contract - is any agreement enforceable by law.

Co-occurring disorder – see *dual diagnosis*

Coordination - means bringing people together to work together efficiently.

Coordinated services – means that several child-serving or consumer-serving organizations talk with the family or consumer and agree upon a *plan of care* that meets the child's or consumer's needs. These organizations can include mental health, education, juvenile justice, adult criminal justice and child welfare. *Case management* is necessary to coordinate services. Also see *family-centered services* and *wraparound services*.

Counseling - aims to help people develop insight into their problems and identify resources within themselves that they can use to cope more effectively with their situation; see also *psychotherapy*.

Criminal justice system - includes all agencies involved in criminal justice including the police, probation service, courts and prisons.

Crisis - is a time of extreme trouble.

Crisis residential treatment services – are short-term, round-the-clock help provided in a non-hospital setting during a crisis.

Cultural competence/culturally appropriate services – means a set of values, attitudes and practices held by an organization or individual service provider that are sensitive and responsive to cultural differences. These differences can include race and ethnicity, national origin, language, beliefs, religion, age, gender, sexual orientation, physical disability, or family values and customs.

Culture – is the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group.

Cyclothymia – is a lesser form of bipolar disorder with less extreme highs and lows; see also *bipolar disorder*.

Day treatment - includes special education, counseling, vocational training, skill building, crisis intervention, and recreational therapy, provided in conjunction with other mental health services.

De-escalate – means to lower the intensity of a situation; often refers to a way of communicating with a person when they are upset or in crisis.

Deinstitutionalization – is the process of releasing individuals from psychiatric institutions.

Delirium – is a temporary state of cognitive disturbance and fluctuating consciousness resulting from medical conditions such as a high fever, intoxication, shock, or other causes. Symptoms may include anxiety, disorientation, hallucinations, delusions, and incoherent speech.

Delusion – a symptom of many mental illnesses, a delusion is an illogical belief that is held strongly, even in the face of evidence that it is false.

Dementia - is an irreversible deterioration of brain function, affecting memory, thinking and reasoning. It is frequently seen in older patients, and is usually accompanied by emotional disturbances and personality changes. See also *Alzheimer's disease*.

Depression – refers to a spectrum of mood disorders, ranging from passing sad moods to serious, debilitating disease requiring medical treatment. *Major (clinical) depression* is a “whole body” disorder, impacting the patient's *emotions* (feelings of guilt and hopelessness or loss of pleasure in once enjoyed activities), *thinking* (persistent thoughts of death or suicide; difficulty concentrating, remembering, or making decisions), *behavior* (changes in sleep patterns, appetite, or weight), and even their *physical well-being* (persistent symptoms, such as headaches or digestive disorders, that do not respond to treatment); see also *bipolar disorder*.

Disability – is a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Discharge plan - is a care plan for people being discharged from a hospital or residential center.

Discharge planner – is the person on the hospital or residence staff who makes plans for an individual's health care outside of the hospital; this can be a nurse, doctor, resident/intern, or social worker.

Disclose – means to share or make known.

Dissociative disorders – are a class of disorder characterized by a disruption in consciousness, memory, identity, or perception, often following a traumatic event; includes *dissociative amnesia* (memory gaps related to trauma or extreme stress); *dissociative fugue* (where an individual assumes a new identity after a traumatic event); *depersonalization disorder* (where a person feels that their body does not belong to them); and *dissociative identity disorder*, also known as *multiple personality disorder* (the presence of two or more distinct personalities within one individual).

Diverse – means differing from one another.

Diversion - refers to the movement of an individual from the criminal justice system to health and/or social care.

Drop-in centers - are venues without structured activity where consumers can socialize.

Drug dependence - occurs when an individual persists in using a drug despite problems related to the use of the drug, such as legal, health, family, occupational or other problems resulting from the drug use. It can be diagnosed either with or without physical dependence, which means issues of tolerance to and withdrawal from the substance.

DSM-IV-TR (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*) – is an official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems.

Dual diagnosis – can mean the combination of mental illness with other conditions, including alcohol abuse, drug abuse, a learning disability, or a physical disability. Also called *comorbidity* or *co-occurring disorders*.

Dyskinesia – is an impairment in the ability to control movements, characterized by spasmodic or repetitive motions or lack of coordination; it is often seen as a side effect from antipsychotic medications see also *tardive dyskinesia*.

Dysthymia – is a lesser, but more persistent, form of depression; see also *depression*.

Early intervention – is a process used to recognize warning signs for mental health problems and to take early action against factors that put individuals at risk.

Eating disorders – are a class of disorders characterized by disturbances in eating behavior; includes *anorexia nervosa* and *bulimia nervosa*.

Electroconvulsive therapy – is a treatment for serious mental illnesses, [such] as severe depressive disorders, involving the application to the head of electric current in order to induce a seizure: usually administered after sedatives and muscle relaxants. *Abbreviation:* ECT

Eligibility criteria - are guidelines used when a person seeks mental health services to determine the priority of their need and the degree of risk, in order to make decisions about the appropriate use of services. These may include age, disability, income, or type of insurance.

Emergency and crisis services - a group of services that is available 24 hours a day, 7 days a week, to help during a mental health emergency. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams, and crisis respite care.

Empathize – means to identify with or develop an understanding of another's situation, feelings, or motives.

Empower - means to give authority, control and confidence to a previously disadvantaged group or person.

Environmental approach – is an approach to mental health treatment that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Epidemiology – is the study of statistics and trends in health and disease across communities.

Evaluation – is the systematic investigation of the value and impact of an intervention or program.

Evidence-based – means programs that have undergone scientific evaluation and have proven to be effective.

Factitious disorder - is a mental disorder where an individual intentionally produces or feigns symptoms in order to assume to “sick role” and be cared for or pitied by others.

Family-centered services – are services designed to meet the specific needs of each individual child and family; see also *appropriate services, coordinated services, wraparound services, and cultural competence*.

Family focused — means an approach to designing and providing services that views the child as a member of a family and recognizes that everyone in a family can be affected by how the others act, what they say, or how they feel or are doing in school or work. Decisions about services are made considering the strengths and needs of the family as a whole as well as the individual child with a mental health problem.

Family support services – are services designed to keep the family together, while coping with mental health problems that affect them. These services may include consumer information workshops, in-home supports, family therapy, parenting training, crisis services, and respite care.

Forensic psychiatry - means psychiatry pertaining to or connected with courts of law.

Frequency – refers to the number of occurrences of a disease or injury in a given unit of time.

Gatekeepers – are those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons with mental health needs and refer them to treatment or supporting services as appropriate.

Generalized anxiety disorder - is a disorder characterized by a pattern of excessive worry and anxiety that is difficult to control and is accompanied by increased physiological arousal (such as restlessness, muscle tension, sleep disturbance, irritability, difficulty concentrating, or being easily fatigued).

Goal – is a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Hallucination – is a false or distorted perception of objects or events, including sensations of sight, sound, taste, smell, or touch, typically accompanied by a powerful sense of their reality.

Health care - is medical and nursing care.

Health promotion - enables people to increase their control over the factors that influence their health, thereby improving their health.

Holistic - means considering the whole person in the treatment of their illness; i.e. their physical, emotional, psychological, spiritual and social needs.

Home-based services – refers to help provided in a family's home either for a defined period of time or for as long as it takes to deal with a mental health problem without removing the child from the home; these can include parent training, counseling, and working with family members to identify, find, or provide other necessary help. Also called *in-home supports*.

Homelessness - describes people living in a broad spectrum of unsatisfactory housing conditions ranging from cardboard boxes and park benches through night shelters and direct access hostels to bed a breakfast accommodation or even sleeping on a friend's floor.

Hospital leave – is the right to leave the hospital grounds temporarily, often with a family member or care provider; leave must be approved by the hospital staff.

Hypomania - is where someone is mildly manic (high); see *mania*.

Impulse control disorders – are a class of specific disorders where it is impossible or extremely difficult for an individual to control impulses, despite the negative consequences; includes *intermittent explosive disorder* (failure to resist aggressive, violent or destructive impulses), *kleptomania* (stealing objects that are not needed), *pyromania* (starting fires for pleasure or relief of tension); *pathological gambling*, and *trichotillomania* (pulling out one's own hair).

Imminent – means likely to happen at any moment.

Independent living services – refers to support for a young person living on his or her own, which teaches youth how to handle financial, medical, housing, transportation, and other daily living needs, as well as how to get along with others. Services may include therapeutic group homes, supervised apartment living, and job placement.

Individual service plan – see *service plan*

Individualized services – are services designed to meet the unique needs of each child and family, taking into the needs and strengths, ages, and stages of development of the child and individual family members; see also *appropriate services* and *family-centered services*.

Initial referral — see *intake*

Inpatient hospitalization – refers to mental health treatment provided in a hospital setting 24 hours a day, usually for purposes of diagnosis/evaluation or acute short-term treatment when an individual is in crisis.

Institutionalization - is where people have been conditioned by living and being looked after in a particular place for a long time; it is normally applied to people in hospital but can equally applied to people cared for in their own homes where they have most things done for them.

Intake - is the process an agency or program uses to find out about a consumer or child and family for the first time and determine their eligibility for services; also called *initial referral*; see also *eligibility criteria*.

Internalization – means to take in information, beliefs, or attitudes and make them personal.

Intervention – is a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

Intramuscular injections - are the administration of long-acting medication through injections into muscles.

Managed care – is a way to supervise the delivery of health care services. It may specify which service providers the insured consumer or family can see and may also limit the number of visits and kinds of services that are covered by insurance.

Mania - is abnormal elevation of mood and over-activity seen in bipolar disorder and other affective disorders. It may include the one or more of the following characteristics: tremendous activity and energy levels, an inability or unwillingness to sleep, a rapid flow of ideas, rapid speech and movement, inflated self-esteem, impulsive decision-making, irrational spending of money, lack of inhibition, bizarre behavior, and/or intense insights not normally experienced. See also *hypomania*, *bipolar disorder*.

Manic depression – see *bipolar disorder*

Meaningful occupation - is occupation which is suitable for a person and which they would find personally rewarding.

Means – in the context of completing a suicide/safety assessment, is the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Media - is the term used to describe TV, radio, newspapers and journals.

Mental disorders due to a medical condition – is a way of classifying a mental health problem or symptom that is a secondary symptom of a physical problem (e.g., depression due to a thyroid problem that causes chemical imbalances in the body).

Mental health – refers to the way a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; explore choices; handling stress; relate to other people; and make decisions.

Mental health services – are health services that are specially designed for the care and treatment of people with mental health problems, including mental illness; includes hospital and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

Mental incapacity – is an inability to make decisions for yourself.

Methods – in the context of a suicide/safety assessment, are actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping).

Minority ethnic groups – are groups of people with a culture distinct from the culture of the host country.

Mood disorders – see *affective disorders*

Morbidity– is the relative frequency of illness or injury, or the illness or injury rate, in a community or population.

Mortality – is the relative frequency of death, or the death rate, in a community or population.

Motivation - is an incentive to do something.

Mutual support groups - are groups where service users and/or family members share their experiences and feelings about mental illness and generally help each other; also called *self-help groups*.

Needs assessment - is the process of assessing and monitoring health and social care needs of a population.

Negative symptoms – are symptoms that take away from what is considered “normal,” such as lack of drive or initiative, social withdrawal, and apathy. The term is usually used in reference to schizophrenia.

Neuroleptics – are a group of medications used to treat psychotic illnesses.

Non-discriminatory practice - means treating people as equals notwithstanding differences of race, gender, sexuality, disability, age, etc.; see also *cultural competence*.

Nursing care home – is a home where care is provided by qualified nurses and ancillary staff 24 hours a day.

Objective – is a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often.

Obsessions – are repetitive thoughts which keep on intruding without good reason; see also *obsessive-compulsive disorder*.

Obsessive-compulsive disorder – is a potentially disabling anxiety disorder in which individuals become entrapped in repetitive patterns of thoughts (*obsessions*) and behaviors (*compulsions*) that are senseless, distressing, and extremely difficult to overcome.

Occupational therapist – is a person trained to provide therapy through creative activity that promotes recovery or rehabilitation.

Occupational therapy - assists people to achieve their maximum level of independence through creative or vocational activities and skill-building.

Outcomes - are measurable results, such as a change in the health of an individual or group of people that is attributable to an intervention.

Outputs - are the range, quantity and quality of services provided.

Outreach programs – are programs that send staff into communities to deliver services or recruit participants.

Panic attack - is a discrete period of intense fear or discomfort in which at least four of the following symptoms develop: accelerated heart beat, sweating, trembling, shortness of breath, feeling of choking, chest pain, nausea, dizziness, fear of dying or losing control, numbness, or chills or hot flashes.

Panic disorder – is an anxiety disorder in which a person experiences panic attacks and develops a concern about having additional attacks. People with panic disorder may develop *agoraphobia*.

Paranoia - is a state in which a person suffers unfounded feelings of persecution and believes others are trying to do them harm.

Parent Advocate — is an individual who has been trained to help other families get the kinds of services and supports they need and want. Parent advocates are usually family members who have raised a child with a behavioral or emotional problem and have worked with the system of care and many of the agencies and providers in your community.

Partnership - is working closely with others to achieve agreed common goals.

Patient – refers to a person receiving services in a medical or hospital setting, including inpatient mental health facilities. See also *consumer*.

Personality disorders – are a class of mental disorders characterized by an enduring pattern of thinking, feeling, and behaving which is significantly different from the person's culture and results in negative consequences.

Pharmacist – is a person licensed to sell or dispense prescription drugs.

Phobias – are a group of anxiety disorders characterized by intense, irrational fears, either of particular things or situations, such as snakes, heights, confined spaces, water, or flying (*specific phobias*) or of being embarrassed or humiliated in a social setting (*social phobia*).

Physician assistant – is a person certified to perform certain duties of a medical doctor, such as prescribing medication, performing a physical examination, or ordering diagnostic tests.

Plan of care – is a treatment plan especially designed for each consumer or child and family, based on individual strengths and needs; it establishes goals and suggests appropriate treatment and services.

Policy - is a plan of action or an agreed position adopted by an organization.

Positive symptoms –are behaviors that add to what is considered “normal,” such as delusions, hallucinations, disorganized thinking and agitation; the term is usually used in reference to schizophrenia.

Posttraumatic stress disorder (PTSD) - can occur after one is exposed to a traumatic event, such as war, natural disasters, major accidents, or severe abuse. The person may then develop an intense fear of related situations, heightened general anxiety, flashbacks and/or recurring nightmares.

Prevention – is a strategy or approach that delays or reduces the likelihood of onset of a mental health problem.

Primary care services - is the local network of primary health care and/or local social services centered around a health center.

Primary mental health care clinician – is the health care provider whom an individual sees the most for his/her mental health care; this may be a doctor, physician assistant, psychiatrist, psychologist, nurse, therapist, case manager, or social worker.

Private sector – refers to profit-making agencies; compare to *public sector* and *voluntary sector*.

Protective factors – are factors that make it less likely that individuals will develop a disorder; these may include biological, psychological or social factors in the individual, family or environment.

Provider - is any organization, agency, group of people or individual who supplies a service in the community, home or hospital in return for payment.

Psychiatric disorder – see *mental disorder*.

Psychiatric resident – is a licensed medical doctor who is being trained in a psychiatric specialty at a hospital.

Psychiatrist – is a licensed physician who has completed special advanced training in diagnosing and treating mental disorders following graduation from medical school.

Psychiatry – is the medical science that deals with the origin, diagnosis, prevention, and treatment of mental disorders.

Psychoeducation – is education offered to those with psychiatric disabilities and often their families with the intent of helping them to better understand and cope with their psychiatric disability.

Psychologist – is a non-medical professional who has completed graduate education and training and is qualified to perform psychological research, testing, or therapy.

Psychology – is the science concerned with the individual behavior of humans, including mental and physiological processes related to behavior.

Psychosis – is a group of symptoms in major mental illness that include loss of contact with reality, breakdown of normal social functioning, and extreme personality changes. Psychotic episodes may be short-lived or chronic and worsening. People affected may experience hallucinations and/or delusions .

Psychotherapy – is a form of treatment for mental disorders based primarily on verbal communication between the patient and a mental health professional, often combined with prescribed medication; see also *counseling*.

Psychotic disorders – are a class of disorders characterized by psychosis, delusions or hallucinations; includes *schizophrenia* and *schizoaffective disorder*.

Public sector – refers to any facility maintained or controlled by a central government, local government, or other statutory body; compare to *private sector* and *voluntary sector*.

Rapport – means a friendly relationship with a basis of trust.

Rate – is the number per unit of the population with a particular characteristic, for a given unit of time.

Recovery – according to RCW 71.24, ""Recovery" means the process in which people are able to live, work, learn, and participate fully in their communities."

Rehabilitation - restores skills (e.g., vocational, social, or daily living skills) through treatment or by training.

Rehabilitation specialist – see *case manager*

Regressive behavior – describes thoughts or actions that are typical of earlier life stages, such as infancy or childhood.

Residential care home - provides accommodation with board and personal care, which is registered and inspected by the local authority.

Residential supervisor – is a person in charge of a group home or a unit within a residential treatment facility who helps with the problems of daily living, checks to be sure that residents take their medications, and knows how to handle crises when they occur.

Residential treatment centers – are facilities that provide treatment and supervision 24 hours a day to groups of consumers or children with serious emotional disturbances. Treatment may include individual, group, and/or family therapy as well as behavior therapy, special education, recreation therapy, and medical services; also called *therapeutic group homes*.

Resilience – refers to the capacities within a person that promote positive outcomes, such as mental health and well being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Respite care – is a temporary break for the caregiver of a child, an older adult, or someone who is ill or disabled. This can be a formal service where a trained caregiver takes care of the person for a while, or informal help provided by a friend or relative.

Review - means a critical look at what exists.

Revise - means to change what exists.

Revised Codes of Washington (RCW's) – are laws that the state government creates; see also *Washington Administrative Codes (WAC's)*.

Risk assessment - is an assessment of whether a person is at risk to themselves or others.

Risk factors – are certain factors that make it more likely that individuals will develop a mental disorder. Risk factors may include biological, psychological or social factors in the individual, family and environment, and are especially significant for children.

Schizoaffective disorder - is a mental illness in which symptoms of both schizophrenia and a manic, depressed, or mixed episode occur at the same time.

Schizophrenia – is a complex and severe mental disorder, which results in abnormal thinking and behavior, including hallucinations (especially hearing voices), delusions, paranoia, social withdrawal, distorted thought processes, and inappropriate or “blunted” emotional expression.

Screening – refers to the administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment; see also *eligibility criteria, intake*.

Screening tools – are those instruments and techniques (questionnaires, check lists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems; see also *eligibility criteria, intake*.

Seclusion - is the supervised confinement of a patient alone in a room, which may be locked.

Self-harm – refers to the various methods by which individuals injure themselves, with or without suicidal intent, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness; also called *self-injury*.

Self-help groups - see *mutual support groups*

Self-injury – see *self-harm*

Self-management - is where a patient manages their own illness and treatment, including recognizing the need to seek help if there are indications of relapse.

Serious – in reference to mental health, means something is important and demands consideration.

Serious emotional disturbances – are diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. These disorders include depression, attention-deficit/hyperactivity, anxiety disorders, conduct disorder, and eating disorders.

Service – is a type of support or clinical intervention designed to address the specific mental health needs of a consumer or a child and his or her family. A service could be provided only one time or repeated over a course of time.

Service coordinator – see *case manager*

Service plan — is a written document that lists and describes all the services and supports a consumer or child and family will receive. Typically, service plans also include information about the consumer's strengths, problems, and needs; describe what the services and supports are designed to accomplish; and explain how and when progress will be assessed. Also called *individual service plan* or *treatment plan*.

Service provider - see *provider*

Severe – in reference to mental health, means something that is violent, extreme and making great demands upon an individual, family, or service provider.

Sheltered work - is work provided for people with a mental illness or developmental disability in protected or well-monitored settings, outside the usual workforce; compare to *supported employment*.

Side effects - are the unwanted physical effects of taking medication.

Sleep disorders – involve abnormalities in the amount, timing or quality of sleep (*dysomnias*) or unusual behavioral or physiological events related to sleep (*parasomnias*).

Social services – are organized efforts to advance human welfare, such as home-delivered meal programs, support groups, and community recreation projects.

Social support – refers to assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Social worker – is a graduate of a school of social work who holds either a bachelor's or master's degree and who is trained in effective ways of helping the people living with mental illness, and other groups in need of assistance. See also *case manager*.

Solvent abuse - is where people get "high" through breathing in fumes from butane, aerosols, glues or other products; see also *substance abuse* and *substance dependence*.

Somatiform disorders – are mental disorders where the symptoms suggest a medical condition, but where no medical condition can be found by a physician; also called *psychosomatic illnesses*.

Spiritual - relates to the spirit or soul as distinct from physical matters; it includes religion but goes much wider to embrace, for example, art and music.

Split personality – is a slang term often *inaccurately* associated with schizophrenia and multiple personality disorder.

Stakeholder – is anyone, including organizations, groups and individuals, that is affected by and contributes to decisions, consultations and policies.

Statutory - relates to organizations set up by law, statute or regulation (e.g. county council, local authority).

Stigma – is a general term for the widespread fear and misunderstanding of mental illness, together with the stereotyping and negative attitudes toward those who suffer from them.

Street drugs – means drugs that are not prescribed by doctors for the person using them; also called *illicit drugs*.

Strengths — are the positive characteristics of any individual, child or family, including things they do well, people they like and activities they enjoy.

Subpoena – is a written legal order.

Substance abuse - is the use of a substance (e.g., alcohol, prescription drugs, street drugs, solvents, etc.) to the point that it has a negative impact on one's life (e.g., leads to fights, arrests, relationship problems, etc.); compare to *substance dependence*.

Substance dependence – is addiction to a substance (see above); i.e., the substance is taken more frequently, in higher doses, in inappropriate situations, or in spite of the user's desire to quit; compare to *substance abuse*.

Suicidal act – is a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries; also called a *suicide attempt*.

Suicidal behavior – refers to a spectrum of thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide; also called *suicidality*.

Suicidal ideation – means self-reported thoughts of engaging in suicide-related behavior.

Suicide – means the act of intentionally killing oneself.

Suicide survivors – are family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Support - means to help, provide for and encourage a person.

Supported employment - is where a person is supported (usually by an organization or program) to obtain and retain open employment in the community; compare to *sheltered work*.

Supported housing - is where residents have their own accommodation, but a member of staff is available to provide support when necessary.

Symptom – is a reported feeling or specific observable physical sign of a consumer's condition that indicates a physical or mental abnormality.

System of care — is a coordinated network of agencies and providers that make a full range of mental health and other necessary services available consumers or children with mental health problems and their families.

Tardive dyskinesia – is a neurological syndrome caused by the long-term use of psychoactive drugs. It is characterized by repetitive, involuntary, purposeless movements such as grimacing, tongue protrusion, lip smacking, puckering and pursing, rapid eye blinking, rapid movements of the arms, legs, and trunk, and involuntary movements of the fingers.

Telecommuting – means participating in work activity from home using a computer linked to the workplace through the Internet.

Treatment - means a medical or psychological therapeutic intervention.

Treatment plan – see *service plan*

Treatment team- is a group of professionals, service providers, family members and/or support people who meet to develop, implement and review a comprehensive service plan for an adult consumer or child and family.

Unintentional – means an injury that is unplanned; also called *accidental injuries*.

Utilization management guidelines – are policies and procedures that are designed to ensure efficient and effective delivery (utilization) of services in an organization.

Voluntary organization - is an organization that is governed by and usually operated by unpaid members and is registered as a charity.

Voluntary sector - refers to the activities of voluntary organizations; compare to *private sector* and *public sector*.

Volunteers - are unpaid helpers, who may have their expenses reimbursed; generally they need to agree to conform to the practices of the organization they are helping.

Washington Administrative Codes (WACs) - set out guidance for practitioners on the operation of legislation. These rules are derived from the *Revised Codes of Washington (RCWs)*, the laws that the state legislature has created.

WRAP – refers training on and use of the Wellness Recovery Action Plan developed by Mary Ellen Copeland.

Wraparound services – are individualized community-based services that focus on the strengths and needs of a child and family. Wraparound services are developed through a team-planning process, where a team of individuals who are relevant to the well-being of the child (such as family members, service providers, teachers, and representatives from any involved agency) collaboratively develop and implement an individualized plan of care, known as a wraparound plan.

Appendix 2: Acronyms

AA - Alcoholics Anonymous

AAA – Area Agency on Aging

ACS - Access to Care Standards

ACT – Assertive Community Treatment

ADA - Americans with Disability Act

ADHD - Attention Deficit Hyperactive Disorder

ADL – Activities of Daily Living

ADSA – Aging and Disabilities Services Administration

AFDC - Aid to Families with Dependent Children

AFH – Adult Family Home

APS – Adult Protective Services

ASL – American Sign Language

CA – Children’s Administration

CASA – Court Appointed Special Advocate

CBT – Cognitive Behavioral Therapy

CCS – Catholic Community Services

CD – Chemical Dependency

CDP- Chemical Dependency Professional

CFR – Code of Federal Regulations

CHINS - Child In Need of Services

CIT – Crisis Intervention Training

CLIP - Children's Long-term Inpatient Programs

CMHA – Community Mental Health Agency

CMS – Centers for Medicare and Medicaid Services

CPC – Certified Peer Counselor

COD – Co-Occurring Disorders

COPS – Consumer Operated Programs & Services

CPS - Child Protective Service

CRC - Crisis Residential Center

CSO – Community Service Office

CSTC - Child Study and Treatment Center

CVAB – Consumer Voices Are Born

DBHR – Division of Behavioral Health & Recovery

DBT – Dialectical Behavioral Therapy

DD – Developmental Disability

DDD - Division of Developmental Disabilities

DL – Disability Lifeline

DMHP - Designated Mental Health Professional

DOH – Department of Health

DRW - Disability Rights of Washington

DSHS - Department of Social and Health Services

DSM-IV-TR- Diagnostic and Statistical Manual (4th edition) Text Revision

DVA – United States Department of Veterans Affairs

DVR - Division of Vocational Rehabilitation

Dx - Diagnosis

E & T - Evaluation and Treatment facility

EBP – Evidence Based Practice

EEOC – Equal Employment Opportunity Commission

EPSDT - Early Periodic Screening, Diagnosis & Treatment

EQRO – External Quality Review Organization

ESD - Educational Service District

ESL – English as a Second Language

ESH – Eastern State Hospital

FACT – Forensic Assertive Community Treatment

FAE/FAS - Fetal Alcohol Effects/Fetal Alcohol Syndrome

FERPA – Family Educational Rights & Privacy Act

FFCMH – Federation of Families for Children's Mental Health

FRS - Family Reconciliation Services

GA – Gamblers Anonymous

GLBT(Q) – Gay Lesbian Bisexual Transgender (Questioning)

HHS – United States Department of Health and Human Services

HMO - Health Maintenance Organization

HIPAA - Health Insurance Portability and Accountability Act

HR – Human Resources

HWD – Healthcare for Workers with Disabilities

ICCD – International Center for Clubhouse Development

IDEA – Individuals with Disabilities Education Act

IDDT – Integrated Dual Disorder Treatment

IEP - Individualized Education Plan

IMR – Illness Management & Recovery

ISP – Individualized Service Plan

IST - Interagency Staffing Team

ITA - Involuntary Treatment Act

ITC - Individualized and Tailored Care

JAN – Job Accommodation Network

JRA - Juvenile Rehabilitation Administration

L & I – Department of Labor and Industries

LCSW – Licensed Clinical Social Worker

LD – Learning Disability

LMFT – Licensed Marriage & Family Therapist

LOS - Length of Stay

LRA – Least/Less Restrictive Alternative

LRE – Least/Less Restrictive Environment

MCO - Managed Care Organization

MDT - Multidisciplinary Team

MHD - Mental Health Division (outdated; now Division of Behavioral Health & Recovery)

MHA – Mental Health Action (in WA State) OR Mental Health Association
(national)

MHFA – Mental Health First Aid

MHHC - Mental Health Housing Consortium

MHP - Mental Health Professional

MHTP - Mental Health Transformation Project

NA – Narcotics Anonymous

NAMI - National Alliance on Mental Illness

NAPS– National Association of Peer Specialists

NIH – National Institute of Health

NIMH – National Institute of Mental Health

NMHA – National Mental Health Association

OA – Overeaters Anonymous

OAH – Office of Administrative Hearings

OCP - Office of Consumer Partnerships

OCR - Office of Civil Rights

OEF/OIF – Operation Enduring Freedom/Operation Iraqi Freedom (veterans)

OSPI - Office of Superintendent of Public Instruction

OT - Occupational Therapist/Therapy

PACT – Program for Assertive Community Treatment

PASS – Plan for Achieving Self Support

PAVE – Partnerships for Action, Voices for Empowerment

PCP – Primary Care Provider OR Person-Centered Planning

PHI – Protected Health Information

PIHP - Prepaid Inpatient Health Plan

PSSP – Peer Support Service Plan

PT – Physical Therapist/Therapy

PTSD - Post Traumatic Stress Disorder

QA - Quality Assurance

QI - Quality Improvement

QRT - Quality Review Team

RC – Registered Counselor (outdated)

RCW - Revised Codes of Washington

RN – Registered Nurse

RSN - Regional Support Network

RTF - Residential Treatment Facility

Rx – Medical Prescription

SA – Substance Abuse OR Sexual Abuse

SAMHSA – Substance Abuse and Mental Health Services Administration

SBD - Serious Behavioral Disturbance

SE – Supported Employment

SED - Serious Emotional Disorder

SEIU – Service Employees International Union

SGA – Substantial Gainful Activity

SMI – Serious/Severe Mental Illness

SSA – Social Security Administration

SSDI - Social Security Disability Insurance

SSI - Supplemental Security Income

TACID - Tacoma Area Coalition for Individuals with Disabilities

TANF – Temporary Assistance for Needy Families

TBI – Traumatic Brain Injury

TE – Transitional Employment

TWE – Trial Work Experience

TWP – Temporary Work Placement

Tx – Treatment

USPRA – United States Psychiatric Rehabilitation Association

VA – (United States Department of) Veterans Affairs

WAC - Washington Administrative Code

WADADS – Washington Dads (parent organization)

WCMHC – Washington Community Mental Health Council

WDVA – Washington State Department of Veterans Affairs

WIMHRT – Washington Institute for Mental Health Research & Training

WIPA – Work Incentives Planning & Assistance

WPAS – Washington Protection & Advocacy Service

WRAP - Wellness Recovery Action Plan

WSCC – Washington State Clubhouse Coalition

WSH – Western State Hospital

YNA – Youth “N” Action

Youth MOVE – Youth Motivating Others through Voices of Experience

Appendix 3: Clinical Terms

Certified peer counselors are often very curious about the definitions of the clinical terms that they hear at their places of employment. Understandably, certified peer counselors want to understand the terms they hear clinicians discuss. If you are curious about what these terms mean, good discussions are available at www.nami.org. (NAMI is the acronym for National Alliance on Mental Illness.) If you do not have access to the Internet, you may call NAMI's helpline at 1-800-950-NAMI (6264).

Remember that one of your strengths as a helper stems from your regard of your peer as a whole person and not merely a diagnosis. In addition, certified peer counselor training does not prepare you to properly use these terms in speech and writing.

Appendix 4: Community Resources

4.A Housing for Homeless People Resource Guide

The excellent Housing Resource Guide is available at http://www.dshs.wa.gov/pdf/dbhr/mh/resourceguide/homeless_resource_guide.pdf

The guide lists statewide resources for emergency shelter, transitional housing, and permanent supportive housing and is current as of October 2008. The guide is almost 100 pages long, which prevents us from reprinting it here. If you do not have access to the Internet, you might ask your provider for help in viewing or printing this guide. Any mental health provider agency will find this resource valuable.

4.B Substance Abuse and Problem Gambling

Accessing Substance Abuse Services:¹ Persons interested in finding out about drug and alcohol services in their community can look under "Washington State Alcohol/Drug" in the Blue Pages of the telephone directory.

The Washington Recovery Help Line is the *new* consolidated help line for substance abuse, problem gambling and mental health, as authorized and funded by the Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery. The Recovery Help Line is a service of Crisis Clinic and serves residents in Washington State.

Washington Recovery Help Line

24-Hour Help for Substance Abuse, Problem Gambling & Mental Health

Call 866.789.1511 or go to <http://www.warecoveryhelpline.org/>

¹ This information taken from www.dshs.wa.gov/DASA/ on May 10, 2009.

Additionally, the following link will take you to Washington's "Directory of Washington State Residential Treatment Agencies that Accept Publicly Funded Chemical Dependency Treatment Patients":

<http://www.dshs.wa.gov/pdf/dbhr/Residential%20Provider%20Directory.pdf>

4.C Community Mental Health Services

Each Regional Support Network (RSN) in the state maintains a network of community mental health centers and other treatment providers. You may access a current listing of the mental health providers in your RSN through the "Benefits Booklet", available at:

<http://www.dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml>

The local ombudsman contact information is also included in this booklet.

Appendix 5: HIPAA ²

The *Standards for Privacy of Individually Identifiable Health Information* (“Privacy Rule”) establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services (“HHS”) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The Privacy Rule standards address the use and disclosure of individuals’ health information—called “protected health information” by organizations subject to the Privacy Rule — called “covered entities,” as well as standards for individuals’ privacy rights to understand and control how their health information is used.

Protected Health Information. The Privacy Rule protects all “*individually identifiable health information*” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information “protected health information.”

“Individually identifiable health information” is information, including demographic data, that relates to:

- the individual’s past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

² This information taken from <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html> on May 15, 2009.

Appendix 6: The ADA - Americans with Disabilities Act³

What is the intent of the ADA?

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in employment; state and local government activities; public accommodations; public transportation; telecommunications; and public services. It was signed into law by President George H. W. Bush on July 26, 1990.

Does the ADA protect people with severe mental illness?

The definition of disability in the ADA includes people with mental illness who meet one of these three definitions: "(1) a physical or mental impairment that substantially limits one or more major life activities of an individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment." A mental impairment is defined by the ADA as "any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities."

³ Used with permission from:
<http://www.nami.org/Template.cfm?Section=Helpline1&template=/ContentManagement/ContentDisplay.cfm&ContentID=4862>

I. Employment (Title I of the ADA)

Do all employers have to comply with Title I of the ADA?

Private employers with 15 or more employees, state and local governments, employment agencies, labor organizations, and management committees are all subject to the ADA. The ADA does not apply to the federal government; however, discrimination by the federal government or federally assisted programs is prohibited under Title V of the Rehabilitation Act of 1973.

Who is protected by Title I?

The ADA prohibits discrimination against "qualified individuals with disabilities" who are individuals with disabilities who meet the skill, experience, education, and other job-related requirements of a position held or desired and who, with or without reasonable accommodation, can perform the essential functions of a job.

To offer ADA protection, does the employer have to be aware of the disability?

Yes. Employers are obligated to make reasonable accommodation only if they are aware of a person's disability. Thus, employers do not have to accommodate disabilities that they are unaware of. If an employee with a known disability is having difficulty performing his or her job, an employer may inquire whether the employee is in need of a reasonable accommodation. In addition, if the employer has reason to know that the employee has a disability, they may have an obligation to discuss reasonable accommodation. In general, however, it is the responsibility of the individual with the disability to inform the employer that an accommodation is needed.

Does the ADA forbid blanket inquiries into your medical and psychiatric history during the hiring process?

Yes. However, an employer may ask you objective questions that help the employer decide whether you can perform essential duties of a job. An employer may ask you about your ability to meet the physical standards for jobs involving physical labor, your ability to get along with people, or your ability to finish tasks on time and to come to work every day.

The ADA requires employers who provide "reasonable accommodations" for qualified individuals with disabilities. What are "reasonable accommodations" for people with severe mental illness?

Examples of reasonable accommodations for people with severe mental illnesses included providing self-paced workloads and flexible hours, modifying job responsibilities, allowing leave (paid or unpaid) during periods of hospitalization or incapacity, assigning a supportive and understanding supervisor, modifying work hours to allow people to attend appointments with their psychiatrist, providing easy access to supervision and supports in the workplace, and providing frequent guidance and feedback about job performance.

What employment practices are covered?

All aspects of an employment relationship including recruitment, hiring, job assignments, pay, lay-off, firing, training, promotions, benefits, and leave.

Are there any exceptions to the requirements of Title I of the ADA?

Yes. There are two exceptions to the requirements of Title I of the ADA. First, an employer is not required to provide an accommodation if it will impose an "undue hardship" on the operation of its business such as accommodations that are excessively costly, extensive, substantial, or

disruptive, or would fundamentally alter the nature or operation of the business.

Second, an employer may refuse to employ or provide accommodations to an individual who poses a "direct threat" to the health or safety of him/herself or other employees in the workplace. The determination that an individual poses a direct threat to self or others cannot be made simply based on stereotypical generalizations about mental illness, but may be based only on objective evidence from a treatment provider or another credible source that the individual's present condition makes him or her a direct threat to self or others.

How does one file a complaint under Title I of the ADA?

An individual who feels that he or she has been discriminated against in employment on the basis of disability can file a charge with the Equal Employment Opportunity Commission (EEOC) **within 180 days of the alleged discriminatory act**. (In certain states that have their own laws prohibiting employment discrimination based on disability this time limit may be extended to 300 days, but, as a general principle, the time limit is 180 days). The EEOC is authorized to mediate and negotiate a settlement between the individual who files the complaint and the employer. If this fails to resolve the matter, the EEOC has the option of either filing a lawsuit on behalf of the individual or issuing a "right to sue" letter. After a "right to sue" letter has been issued, the individual may file a lawsuit in a federal district court.

II. State and Local Governments (Title II of the ADA)

How does the ADA apply to state and local governments?

Title II of the ADA prohibits discrimination against qualified individuals with disabilities in all programs, activities, and services provided by state and local

governments.

What are examples of state and local governmental activities covered under Title II of the ADA?

A state or local government must eliminate any eligibility criteria for participation in programs, activities, and services that screen out or tend to screen out or discriminate against persons with disabilities, unless it can establish that these requirements are necessary for the provision of the service, program, or activities. For example, a state may not refuse to grant a driver's license to someone merely because of their psychiatric diagnosis, unless the illness or medication taken for the illness interfere with the ability to drive. The ADA also requires that all new buildings constructed by a state or local government be accessible.

How does one go about filing a complaint under title II of the ADA?

Private individuals may file a complaint with the U.S. Department of Justice. To find out how this is done, call 1-800-541-0301. Alternatively, individuals may file lawsuits in a federal district court. Compensatory damages, including damages for pain and suffering may be awarded. Reasonable attorneys' fees may be awarded as well.

III. Public Accommodations (Title III of the ADA)

What is the purpose of Title III of the ADA?

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodations by any person who owns, leases, or operates a place of public accommodation.

What are "places of public accommodations"?

Places of public accommodation include a wide range of entities such as restaurants, hotels, theaters, doctors' offices, pharmacies, retail stores, or museums.

How does one go about filing a complaint under title III of the ADA?

As with Title II, The U.S. department of justice is responsible for administering Title III of the ADA. An individual who believes he or she has been discriminated against in violation of Title III may either file an administrative complaint with the Department of Justice (1-800-541-0301) or file a private lawsuit in a federal district court.

IV. ADA Resource Guide

Who can I call if there is evidence of an ADA violation?

Resource	How to Contact
Private Attorney	
Equal Employment Opportunity Commission (EEOC) <i>for Title I concerns</i>	www.eeoc.gov 800-669-4000
U.S. Department of Justice <i>for Title II and Title III concerns</i>	www.usdoj.gov 800-541-0301
Job Accommodation Network	http://askjan.org/ 800-526-7234
State Protection & Advocacy Agency	www.ndrn.org
Legal services organization (legal aid) in your area	local phone directory

V. Additional Sources of Information

A Technical Assistance Manual on the Employment Provision (Title I) of the ADA. A resource directory published by the U.S. Equal Employment Opportunities Commission. To order a copy, call 800-669-EEOC or visit www.eeoc.gov/policy/docs/psych.html

Opening Public Agency Doors: Title II of the Americans with Disabilities Act and People with Mental Illnesses: A Collaborative Approach for Ensuring Equal Access to State Benefit and Service Programs. Published by the Bazelon Center for Mental Health Law. To order a copy, call 202-467-5730.

Appendix 7: Consumer Rights in Washington State

These are the consumer rights in the State of Washington in the mental health system:

- To be treated with respect and dignity
- To have your privacy protected
- To help develop a plan of care and services that meet your needs
- To participate in decisions regarding your mental health care
- To receive services in a barrier-free location (accessible)
- To request information about names, location, phones, and languages for local agencies
- The right to receive the amount and duration of services you need
- To request information about the structure and operation of the RSN
- The right to services within 2 hours for emergent care and 24 hours for urgent care
- To be free from use of seclusion or restraints
- To receive age and culturally appropriate services
- To be provided a certified interpreter and translated material at no cost to you (the consumer or family member)
- To understand available treatment options and alternatives
- To refuse any proposed treatment
- To receive care that does not discriminate against you (e.g., age, race, type of illness)
- To be free of any sexual exploitation or harassment
- To receive an explanation of all medications prescribed and possible side effects
- To make an advance directive, which states your choices and preferences for mental health care
- To receive quality services that are medically necessary
- To have a second opinion from a mental health professional

- To file a grievance with your agency or RSN
- To choose a mental health care provider or choose one for your child who is under thirteen years of age
- To change mental health care providers during the first 30 days, and sometimes more often
- To file a request for an administrative (fair) hearing
- To request and receive copy of your medical records and ask for changes
- To be free from retaliation

You may want to ask your mental health care provider for more information about your rights. Your rights will be provided to you in writing when you request services. An independent Ombuds may be available in your RSN to help you if you have complaints. When you receive mental health care in a hospital, you have additional rights.

You have the right to request policies and procedures of the RSN and CMHAs as they pertain to your rights.

Appendix 8: FERPA

The Family Educational Rights and Privacy Act (FERPA) is a national law and has three main goals:

1. FERPA gives parents of minor children and adult students (over 18 years of age) the right to inspect and review the student's education records. The system is to respond to the request within 45 days of the day that the system receives the request. A copy of "Request to Inspect Student Educational Records" is available upon request at the student's school. At the time the records are inspected, the requestee must complete a "Log of Inspection of Records."
2. If parents or eligible students feel that a record is not accurate, is misleading, or is in violation of privacy or other rights, FERPA gives them the right to request an amendment of the student's education records. The form "Request to Inspect Student Educational Records" also has a section for this request.
3. FERPA gives the parents or eligible students the right to consent to disclosure of information that is contained in student's school records.

Any school will have a fully developed policy in regard to these rights and you can request to review the policy.

Appendix 9: Importance of Understanding Special Education Laws

This section is intended to highlight the importance of understanding special education laws and rules, both at the state and federal level.

Parent/caregiver empowerment in this arena is highly prioritized as school issues are commonly the most difficult arena parents/caregivers report having to navigate.

The Individuals with Disabilities Education Act (IDEA) is a law ensuring services to children with disabilities throughout the nation. IDEA governs how states and public agencies provide early intervention, special education and related services to more than 6.5 million eligible infants, toddlers, children and youth with disabilities.

The following are recommended resources for you to become educated on Special Education Laws and rules to include IDEA, Individual Education Planning (IEP's) and 504 accommodation planning:

Washington Pave

www.washingtonpave.org

Team Child

www.teamchild.org

Office of Superintendent of Public Instruction

www.k12.wa.us

Wrights Law-Special Education Law and Advocacy

www.wrightslaw.com

Office of Special Education Programs

www.ed.gov/about/offices/list/osers/osep

Appendix 10: Other Resources for Parents/Caregivers and Families

National Alliance on Mental Illness (NAMI)

<http://www.nami.org>

NAMI-Washington

<http://www.namiwa.org/>

NAMI-Greater Seattle

<http://www.nami-greaterseattle.org/>

NAMI-GS also offers a toll free helpline serving the entire state:

1-800-782-9264.

Washington PAVE

<http://www.washingtonpave.org/>

Substance Abuse and Mental Health Services Administration Children's Mental Health section

<http://www.samhsa.gov/children/>

WADADS (Washington Dads)

www.wadads.org

Youth "N" Action!

<http://www.youthnaction.org/>

Appendix 11: Reframe Behaviors as Strengths

Common Behavior	Possible Strengths to draw from
Runs away a lot	Has good survival skills, is resourceful
Assaultive	Strength, passion, misguided assertiveness, sticks up for self
Can't sit still, is always talking/moving	Energetic, full of ideas, excited to share ideas, interested in many things, reacts quickly
Disrespectful	Free spirited, projects high esteem, values own opinion, values respect, values justice
Has negative peer group	Able to make friends
Unable to stay on task	Curious and inquisitive
Erupts/blusters out of room	Expressive, learned coping skills, sensitive, capacity for self control
Child can't form relationships	Child is self reliant, independent or has experienced many placements
Bossy	Has leadership qualities
Interrupts others	Values own ideas and thoughts, excited to share information
Oppositional/doesn't follow rules	Has mind of their own, independent, sense of self limits, self directed
Puts self in high risk situations	Brave, adventuresome
Family is always in crisis	Family is adaptable
Family resists assistance	Independent/self-sufficient, doesn't follow blindly, asserts strength, knows what they want/need/fits for them
Parents are enmeshed with child	Parents/caregivers love their child, strong family bond, high sense of responsibility

Appendix 12: Continuing Education for Certified Peer Counselors

Good human service workers always seek continuing education about topics such as networking, resources, self-help, communication, recovery, resilience, WRAP, and consumer organizations. There are no requirements for certified peer counselors to receive continuing education at this point (May, 2009).

Do not assume that the state or your employer “owes” you training funds or time off for training. Some employers do provide limited paid time off for training and a small training budget. However, this is the exception rather than the rule. Your continuing education is one of the responsibilities of working and you will be wise to use your personal resources for training.

You may find free training opportunities delivered by your agency, RSN, DBHR, , consumer agencies, and clubhouses. Some organization offer free teleconferences. Bulletin boards at work are premiere locations for the posting of all training opportunities, free or not. Be sure to let your supervisor know that you prize additional training and request you know when trainings opportunities occur.

Appendix 13: Certified Peer Counselor Job Search Resources

It can be confusing to know where to start looking for a job. Here is a prioritized list for certified peer counselors of places to start.

Start at Work Source at <https://fortress.wa.gov/esd/worksource/>. Enter "All Occupations" in the search form and enter "Peer Support" in the key word part of the search. As this Appendix goes to press (May 2009) there are three peer support jobs listed at this site.

Frequently visit the web page of the Washington Community Mental Health Council at <http://www.wcmhcnet.org/>. Click on the Job Bank link to review jobs state wide in community mental health.

Northwest Seeds of Change is a networking website for consumers, located at <http://www.nwseedsofchange.org/> It has a discussion group specific to Certified Peer Counselors. You must become a member (free) in order to use this site. People often post Peer Support jobs and training opportunities on this site.

Your library has local newspapers where you can look for jobs. You can also use the computer at the library. You may have to reserve times for computer use.

Newspapers have employment sections every day and most have a larger section on Sundays. Newspapers have job listing online and these are often updated daily.

Networking is an important part of job searching. Networking means talking to friends, family and other people you know to find information about jobs and job openings. Start networking by making a list and calling people you know. Ask them to keep you in mind if they hear of openings.

Volunteering is another way to find out about a peer support jobs. Involvement with your community can widen your contacts. Even as little as one evening a week can lead to improved skills and broader contacts.

Visiting job and career fairs helps you become familiar with employers and the job market and gives you experience in inquiring about jobs.

Appendix 14: Sample Resume⁴

NAME

Street • City, State Zip • Phone • Email

JOB OBJECTIVE

Very concisely state what job you would like next.

HIGHLIGHTS OF QUALIFICATIONS

- Write three or four bullet statements that summarize why you would be good at your job objective. Each statement should be no longer than two lines.
- Your statements should highlight your relevant strengths such as experience, skills, community service, and personality traits.
- Prioritize the statements in this section so the most relevant one comes first.

PROFESSIONAL ACCOMPLISHMENTS

KEY SKILL

- Write two or more bullet statements about employment or volunteer activities in which you used this skill.
- Quantify results of your accomplishments when possible and appropriate; refer to how you positively affected the organization, the bottom line, your boss, co-workers, or customers.
- Mention awards or commendations you received that required this skill.
- If you used this skill to solve problems, briefly describe the problems and results.

KEY SKILL

- Write two or more bullet statements, following the tips mentioned under the first Key Skill section.
- Prioritize the statements under each Key Skill section so the most relevant one comes first.

WORK HISTORY

20xx-present	ORGANIZATION, City, State Job Title
19xx-xx	ORGANIZATION, City, State Job Title
19xx-xx	ORGANIZATION, City, State Job Title

EDUCATION

Degree, Major [if relevant], 20xx
School, City, State

COMMUNITY SERVICE

Position held, Organization, 20xx-present
Position held, Organization, 20xx-xx

⁴ From: <http://jobstar.org/tools/resume/samples.php>

Appendix 15: Where to Find More Information on Social Security Benefits and a Guide to Work Incentives (“the Red Book”)

One of the Social Security Administration's (SSA) highest priorities is to support the efforts of disabled beneficiaries who want to work by developing policies and services to help them reach their employment goal. To that end, the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs include a number of employment support provisions commonly referred to as work incentives.

The Red Book is a general reference tool designed to provide a working knowledge of these provisions. The Red Book is written primarily for educators, advocates, rehabilitation professionals, and counselors who serve individuals with disabilities. The Social Security Administration also expects that applicants and beneficiaries will use it as a self-help guide.

The Social Security Administration publishes the Red Book Social Security Handbook for Individual Disabilities (Employment Supports, Supplemental Security Income and Social Security Disability Insurance). This handbook can be found online and downloaded at: <http://www.ssa.gov/redbook/>

Appendix 16: Disclosing Your Disability to an Employer

To be hired as a Certified Peer Counselor, you must identify yourself to your employer and your peers as a consumer of mental health services (a “consumer” in the state’s definition includes a parent of someone with a mental health diagnosis). Lived experience is one of the strengths that Certified Peer Counselors bring to their jobs. However, you **are not** required to disclose your diagnosis or any specifics about your past or present mental health treatment to your employer. This is a personal decision. This sections looks at some considerations around what and how much to disclose. In addition, this section can be useful if you are working with a peer who is considering disclosing his/her psychiatric disability to an employer.

⁵Only you can decide whether and how much to tell your employer about your psychiatric disability. Telling your employer about your diagnosis is the only way to protect your legal right to any accommodations you might need to get or keep a job. However, revealing your disability may subject you to discrimination which could limit your opportunities for employment and advancement.

Disclosure is a complex decision and should be made with care. Here's what you might want to think about:

Preparing to Disclose

1. Assess your employment skills to determine whether you need help from your therapist or mental health agency to:

- Initiate contact or arranging an interview with the employer interview.

⁵ Adapted from the Center for Psychiatric Rehabilitation at Boston University, <http://www.bu.edu/cpr/jobschool/disclosing.htm>

- Describe your disability.
- Negotiate the terms of employment.
- Negotiate accommodations.

2. Identify any potential accommodations you might need during the hiring process or on your first day of work.

3. Explore your feelings about having a mental illness and about sharing that information with others -- remember, no one can force you to disclose if you don't want to.

4. Research potential employers' attitudes toward mental illness and screen out unsupportive employers.

- Have they hired someone with a psychiatric disability before?
- Do they personally know someone with a mental illness?
- What positive or negative experiences have they had in employing someone with a mental illness?
- Do they show signs -- newsletters, posted notices, employee education programs about mental illness, etc. -- of encouraging a diverse workforce?
- Do they have a corporate culture that favors flex time, mentoring programs, telecommuting, flexible benefit plans, and other programs that help employees work efficiently and well?
- Does the job have certain requirements (e.g., child care, high security, some government positions) that would put you at a disadvantage if you disclosed your diagnosis?

5. Weigh the benefits and risks of disclosure

- Do you need to involve an outside agency to get or keep the job?

- Do you need accommodation or other employer support?
- When will you need this accommodation?
- Do other people in the company need similar accommodation?
- How stressful will it be for you to hide your disability?

6. If you decide not to disclose, find other ways to get the support you need

- Behind-the-scenes support from friends, therapists, etc.
- Research potential employers who provide these supports to all employees.

7. If you decide to disclose, plan in advance how you'll handle it

- Who will say it (you, your therapist, your job coach, etc.).
- What to say (see below).
- When to say it.

Under the ADA, a person with a disability can choose to disclose at any time, and is not required to disclose at all unless s/he wants to request an accommodation or wants other protection under the law. Someone with a disability can disclose at any of these times:

- Before the hiring interview.
- During the interview.
- After the interview but before any job offer.
- After a job offer but before starting a job.
- Anytime after beginning a job.
- We recommend disclosing sometime before serious problems arise on the job. It is unlikely that you would be protected under the ADA if you disclosed right before you were about to get fired. Employers

are most likely to be responsive to a disclosure if they think it is done in good faith, and not as a last-ditch effort to keep your job.

8. Who to tell

- Your supervisor or manager, if he or she must provide or approve an accommodation.
- The EEO/Affirmative Action officer or Human Resources staff, if no immediate accommodation is needed, but you would like the protection of the ADA.
- The person interviewing you or Human Resources staff, if you might need accommodation during the hiring process.
- The Employee Assistance Program staff, if you are already on the job, experiencing difficulties, and need help deciding how, how much, and to whom to disclose.

When You Disclose

1. Decide how specific you will be in describing your psychiatric disability.

- General terms: a disability, a medical condition, an illness.
- Vague but more specific terms: a biochemical imbalance, a neurological problem, a brain disorder, difficulty with stress.
- Specifically referring to mental illness: a mental illness, psychiatric disorder, mental disability.
- Your exact diagnosis: schizophrenia, bipolar disorder, major depression, anxiety disorder.

2. Describe the skills you have that make you able to perform the main duties of the job.

- Qualifications technical skills

- General work skills

3. Describe any functional limitations or behaviors caused by your disability which interfere with your performance (See Steps to Define Functional Limitations).

4. Identify the accommodations you need to overcome those functional limitations or behaviors (See Steps to Identify Reasonable Accommodations).

5. Optional: You may choose to describe the behaviors or symptoms the employer might observe and tell the employer what steps to take as a result.

6. Point the employer to resources for further information.

- Employment specialist, supported employment provider, rehabilitation counselor, job coach, doctor, psychiatrist, therapist, counselor, social worker.
- Job Accommodation Network (JAN).
- ADA Disability and Business Technical Assistance Centers.

You may find it helpful to prepare a script to read from. For example: "I have (preferred term for psychiatric disability) that I am recovering from. Currently, I can/have (the skills required) to do (the main duties) of the job, but sometimes (functional limitations) interfere with my ability to (duties you may have trouble performing). It helps if I have (name the specific accommodations you need). I work best when (other accommodations)." You could also add the following information: "Sometimes you might see (symptoms or behaviors associated with symptoms). When you see that, you can (name the action steps for the employer). Here is the number of my (employment specialist, doctor, therapist, previous employer, JAN, etc.) for any information that you might need about my ability to handle the job."

Appendix 17: Issues and Strategies for Success at Work

On these pages, you'll find a number of common issues faced by employees with psychiatric disabilities, and some strategies to address each issue⁶.

Issue #1: Completing job applications, arranging interviews, and interviewing are all difficult for you.

Strategy: Work with a job coach, who can not only help you learn how to do these things, but can meet with you onsite once you have the job to help you with your training.

Issue #2: Your regular appointment with your therapist is during working hours.

Strategy: Ask your employer for time off to go to your appointment, which would qualify as an accommodation under the [Americans with Disabilities Act \(ADA\)](#). Offer to make up the time by working extra hours on other days or evenings.

Issue #3: Your medicine makes you drowsy in the mornings, making it difficult for you to get to work on time and to function efficiently once you get there.

Strategy:

- Ask your employer to adjust your schedule so your work day starts and ends later in the day; this would qualify as an accommodation under the ADA.
- With the help of your doctor, adjust the type, amount, and timing of your medication to minimize side effects.

Issue #4: Your doctor changes your medications, and your condition deteriorates significantly, negatively affecting your ability to meet the demands of your job.

Strategy: Tell your doctor you're unhappy with the change and want to return to your previous medication. If necessary, ask your therapist to advocate for you.

Issue #5: The medications you need to control your symptoms diminish your alertness, concentration, and energy level.

⁶ Adapted from the Center for Psychiatric Rehabilitation at Boston University, <http://www.bu.edu/cpr/jobschool/office.htm>.

Strategy: With the help of your doctor, adjust the type, amount, and timing of your medication to minimize side effects.

Issue #6: Your symptoms or medications affect your memory.

Strategy: Keep a calendar -- or, better yet, use a calendar program on your computer -- to remind you of meetings, deadlines, project timelines, etc.

Issue #7: You need to take time off work to be hospitalized, but you've used up all your allotted sick leave.

Strategy: Ask your employer to let you take an extended leave without pay. This would qualify as an accommodation under the ADA.

Issue #8: You experience debilitating panic and/or anxiety when you have to walk through a parking lot to get to your car.

Strategy:

- Ask your employer to assign you a parking space closer to the door; this would qualify as an accommodation under the ADA.
- Leave the building with other employees and have one of them walk to your car with you.

Issue #9: You work in an open cubicle surrounded by whirring printers and ringing phones in a busy office where people walk past and stop to chat while you're trying to work. The constant bustle makes it hard for you to concentrate.

Strategy: Ask your employer for a set of accommodations designed to maximize your ability to focus:

- A high-walled cubicle can minimize visual distractions and discourage people from disturbing you while you work.
- Headphones playing soft music can filter out background noise without disturbing your co-workers.
- Replacing your phone's ringer with a blinking light or other visual cue can also increase your sense of calm.
- Receiving instructions in writing or via e-mail gives you something to refer to when you've been distracted.

Issue #10: You have to be hospitalized repeatedly, which affects your ability to complete projects with specific timelines.

Strategy: Consider working on a contract basis, which can be more short-term and time-limited, and which allows your employer to reassign your work to other contract workers if you have to return to the hospital.

Issue #11: You lack access to a computer and computer skills, which makes finding and keeping a job more difficult.

Strategy: Community-based education, such as adult ed programs, can provide computer education at reduced cost.

Issue #12: Lack of transportation makes it hard for you to get to work on time.

Strategy:

- If public transportation isn't available, explore ride-sharing with other employees (by forming a carpool or joining an existing one).
- Check with local psychosocial clubhouses to see if they have transportation resources.

Potential Accommodations on the Job

What Accommodations Work on the Job?

For employees with psychiatric disabilities, reasonable accommodations might include adaptations in the way work is assigned and scheduled, the use of auxiliary equipment and support staff, and modifications to the physical workspace. You will need to negotiate, select, and arrange whatever accommodations you need by working closely with your supervisor and the human resources department. Here are some possible aids and services you may consider:⁷

Restructuring jobs: Having minor job duties eliminated -- for example, assigning "fill-in" duties to another employee -- frees you to focus on your primary responsibilities.

Flexible scheduling: Changing the start or end of the workday to accommodate side effects of medication, working part-time, taking more frequent breaks, taking time off for therapy appointments.

⁷ Adapted from the Center for Psychiatric Rehabilitation at Boston University, <http://www.bu.edu/cpr/jobschool/potentialjob.html>

Flexible leave: Being able to use sick leave for mental health reasons or take an extended leave without pay due to hospitalization.

Specialized equipment & assistive devices: Receiving daily instructions via e-mail instead of verbally.

Modifying work sites: Installing wall partitions around workstation to minimize distractions.

Providing a job coach or mentor: Helps in arranging interviews, completing job applications, and providing support and training on the job.

Changes in training: Allowing extra time to learn job tasks.

Appendix 18: Support for Certified Peer Counselors

People who work in social services need support in handling the life circumstances and feelings presented to them from their clients. Your first support in dealing with this is your supervisor. If for you are working for a large agency or in a densely populated region, you may also have access to a group meeting designed to help certified peer counselors with their feelings about their jobs and the problems that the jobs present for them.

As you learned in this class, the consumer movement is based on self-help, and you can start your own group to promote mutual support, education and growth among certified peer counselors. Use the principles of group support groups set out in this manual and as you practiced in class.

It is important to network with other certified peer counselors in the state about running and maintaining a successful peer support group. A group of certified peer counselors may even consider pooling funds to occasionally hire a consultant to come to their groups to assist them in their deliberations. Use different consultants for different topics and areas of expertise such as resources in different systems of care, discussions of readings about Peer Support, and maintaining relationships with difficult people.

If you are geographically isolated, you might use telephone calls, telephone conference calls and the Internet to create ongoing group consultations.

The National Association of Peer Specialists offers resources for support. Review their website at <http://www.naops.org/index.html>. Click on Calendar Events to learn about upcoming Peer Support events.

Northwest Seeds of Change, a consumer networking website, has a discussion group specific to Certified Peer Counselors. You can sign up as a NW Seeds member at <http://www.nwseedsofchange.org/>

Appendix 19: Peer Support Service Plan (PSSP)

Currently, there is no required **Peer Support Service Plan (PSSP)** in the Washington State system. We include this resource within the appendices to give you a tool for use if your agency practice includes service plan development by certified peer counselors. This resource will guide you on how to build a step-by-step, strengths-based, person-centered goal plan that is also related to the Individualized Service Plan (ISP). The PSSP must relate to the needs or goals identified on the ISP. The peer (consumer or family member) leads the development of the PSSP by choosing what goal they are interested in working to achieve in order to meet a specific need identified on the ISP. In the objectives section, the actual steps that the peer will take to achieve their goal should be described and written in their own words.

Practice PSSP (PEER SUPPORT SERVICES PLAN)	
Need # ___ (from ISP/ITCP)	Strength(s) related to this goal:
Goal: Target Date (MM/DD/YY) ___/___/___	
Consumer Objective 1 (what the consumer/family member will do to reach the goal): Target Date (MM/DD/YY) ___/___/___	

Certified Peer Counselor Intervention or Support for Objective 1:

1. _____ Hours per week
2. _____ Hours per week

Consumer Objective 2 (what the consumer/family member will do to reach the goal):

Target Date (MM/DD/YY)

___/___/___

Certified Peer Counselor Intervention or Support for Objective 2:

1. _____ Hours per week
2. _____ Hours per week

Consumer Objective 3 (what the consumer/family member will do to reach the goal):

Target Date (MM/DD/YY)

___/___/___

Certified Peer Counselor Intervention or Support for Objective 3:

1. _____ Hours per week
2. _____ Hours per week

Consumer/Family Member's Name: (Print) _____

Signature _____ Date _____

Certified Peer Counselor's Name (Print) _____

Signature _____ Date _____

How to Write the PSSP

- 1. Need #:** Discuss the goal and objective of the consumer first, then check to see which need or problem are most closely related in the ISP. Record the number.
- 2. Strengths:** What have you and the consumer learned of his/her strengths and which ones will be used in achieving the objectives of this section?
- 3. Goals:** Goals are broad and may be long-term.
- 4. Objectives:** Objectives are specific and shorter term methods to reach goals. Objectives are the steps that the consumer states s/he will take to reach her/his goals.
- 5. Target Dates:** When will the entire goal and all of this objective be accomplished? Remember to give enough time for no progress or slow progress, and for practicing the objective successfully for awhile.
- 6. The certified peer counselor will... What?** What will the certified peer counselor do to support or assist the peer to achieve the objective? This might be meeting at a certain time each week to talk about how the person is doing with the objective, maybe do some problem-solving with the person or just listen. It might be to do something more concrete, such as rehearsing a telephone call that the consumer needs to make in accessing services.
- 7. Names, signatures and full dates:** These are essential. Without them, you do not have a valid PSSP.
- 8. Provide a copy and keep the original.** Be sure to make a copy for the person being served – it is their plan, after all! Ask your supervisor where to store the other copy and what the policy and procedure is for such storage within the agency.

The PSSP for Children and Families:

- The client/consumer identified on the PSSP should be the child.
- The content of the PSSP should be family-centered rather than focused on the child individually.
- **PSSP Goal:** The primary caregiver (consumer) should determine the goal to be achieved in relation to a need that is identified on the child's Individual Service Plan (ISP).
- **PSSP Intervention:** The primary caregiver (consumer) should define what action will be taken to accomplish the goal.
- **PSSP Objective:** The objective should describe the steps or action taken by the certified peer counselor to facilitate the completion of the goal by the primary caregiver (consumer).

Example PSSP for Children & Families	
Goal:	Jane will meet friends who are involved in things that she likes to do.
Objective 1:	Jane will join her local library's book club, attend on Wednesdays at 7:00 PM and ask at least one person from the group per month to join her for coffee next door at Cafe Express after the meeting.
Objective 2:	Jane will attend the free watercolor painting workshops every other Saturday at 10:00 AM and speak with at least two people there.

Appendix 20: The 10 Fundamental Components of Recovery

The 10 Fundamental Components of Recovery

Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems,

communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their

experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Resources

www.samhsa.gov

National Mental Health Information Center

1-800-789-2647, 1-866-889-2647 (TDD)

Appendix 21: Recommended Reading

Eight barriers to effective listening⁸

More attention is usually paid to making people better speakers or writers (the "supply side" of the communication chain) rather than on making them better listeners or readers (the "demand side"). The most direct way to improve communication is by learning to listen more effectively.

Nearly every aspect of human life could be improved by better listening -- from family matters to corporate business affairs to international relations.

Most of us are terrible listeners. We're such poor listeners, in fact, that we don't know how much we're missing.

The following are eight common barriers to good listening, with suggestions for overcoming each.

#1 - Knowing the answer

"Knowing the answer" means that you think you already know what the speaker wants to say, before she actually finishes saying it. You might then impatiently cut her off or try to complete the sentence for her.

Even more disruptive is interrupting her by saying that you with disagree her, but without letting her finish saying what it is that you think you disagree with. That's a common problem when a discussion gets heated, and which causes the discussion to degrade quickly.

By interrupting the speaker before letting her finish, you're essentially saying that you don't value what she's saying. Showing respect to the speaker is a crucial element of good listening.

The "knowing the answer" barrier also causes the listener to pre-judge what the speaker is saying -- a kind of closed-mindedness.

A good listener tries to keep an open, receptive mind. He looks for opportunities to stretch his mind when listening, and to acquire new ideas or insights, rather than reinforcing existing points of view.

⁸ Used with permission from Michael Webb <http://www.skatch.net/index.html>

Strategy for overcoming this barrier

A simple strategy for overcoming the "knowing the answer" barrier is to wait for three seconds after the speaker finishes before beginning your reply.

Three seconds can seem like a very long time during a heated discussion, and following this rule also means that you might have to listen for a long time before the other person finally stops speaking. That's usually a good thing, because it gives the speaker a chance to fully vent his or her feelings.

Another strategy is to schedule a structured session during which only one person speaks while the other listens. You then switch roles in the next session.

It's worth emphasizing that the goal of good listening is simply to listen -- nothing more and nothing less.

During the session when you play the role of listener, you are only allowed to ask supportive questions or seek clarification of the speaker's points. You may not make any points of your own during this session. That can be tricky, because some people's "questions" tend to be more like statements.

Keeping the mind open during conversation requires discipline and practice. One strategy is to make a commitment to learn at least one unexpected, worthwhile thing during every conversation. The decision to look for something new and interesting helps make your mind more open and receptive while listening.

Using this strategy, most people will probably discover at least one gem -- and often more than one -- no matter whom the conversation is with.

#2 - Trying to be helpful

Another significant barrier to good listening is "trying to be helpful". Although trying to be helpful may seem beneficial, it interferes with listening because the listener is thinking about how to solve what he perceives to be the speaker's problem. Consequently, he misses what the speaker is actually saying.

An old Zen proverb says, "When walking, walk. When eating, eat." In other words, give your whole attention to whatever you're doing. It's worth emphasizing that the goal of good listening is simply to listen -- nothing more and nothing less. Interrupting the speaker in order to offer advice disrupts the flow of conversation, and impairs the listener's ability to understand the speaker's experience.

Many people have a "messiah complex" and try to fix or rescue other people as a way of feeling fulfilled. Such people usually get a kick out of being problem-solvers, perhaps because it gives them a sense of importance. However, that behavior can be a huge hurdle to good listening.

Trying to be helpful while listening also implies that you've made certain judgments about the speaker. That can raise emotional barriers to communication, as judgments can sometimes mean that the listener doesn't have complete respect for the speaker.

In a sense, giving a person your undivided attention while listening is the purest act of love you can offer. Because human beings are such social animals, simply knowing that another person has listened and understood is empowering. Often that's all a person needs in order to solve the problems on his or her own.

If you as a listener step in and heroically offer your solution, you're implying that you're more capable of seeing the solution than the speaker is.

If the speaker is describing a difficult or long-term problem, and you offer a facile, off-the-cuff solution, you're probably forgetting that he or she may have already considered your instant solution long before.

Strategy for overcoming this barrier

Schedule a separate session for giving advice. Many people forget that it's rude to offer advice when the speaker isn't asking for it. Even if the advice is good.

In any case, a person can give better advice if he first listens carefully and understands the speaker's complete situation before trying to offer advice.

If you believe you have valuable advice that the speaker isn't likely to know, then first politely ask if you may offer what you see as a possible solution. Wait for the speaker to clearly invite you to go ahead before you offer your advice.

#3 - Treating discussion as competition

Some people feel that agreeing with the speaker during a heated discussion is a sign of weakness. They feel compelled to challenge every point the speaker makes, even if they inwardly agree. Discussion then becomes a contest, with a score being kept for who wins the most points by arguing.

Treating discussion as competition is one of the most serious barriers to good listening. It greatly inhibits the listener from stretching and seeing a different point of view. It can also be frustrating for the speaker.

Strategy for overcoming this barrier

Although competitive debate serves many useful purposes, and can be great fun, debating should be scheduled for a separate session of its own, where it won't interfere with good listening.

Except in a very rare case where you truly disagree with absolutely everything the speaker is saying, you should avoid dismissing her statements completely. Instead, affirm the points of agreement.

Try to voice active agreement whenever you do agree, and be very specific about what you disagree with.

A good overall listening principle is to be generous with the speaker. Offer affirmative feedback as often as you feel comfortable doing so. Generosity also entails clearly voicing exactly where you disagree, as well as where you agree.

#4 - Trying to influence or impress

Because good listening depends on listening just for the sake of listening, any ulterior motive will diminish the effectiveness of the listener. Examples of ulterior motives are trying to impress or to influence the speaker.

A person who has an agenda other than simply to understand what the speaker is thinking and feeling will not be able to pay complete attention while listening.

Psychologists have pointed out that people can understand language about two or three times faster than they can speak. That implies that a listener has a lot of extra mental "bandwidth" for thinking about other things while listening. A good listener knows how to use that spare capacity to think about what the speaker is talking about.

A listener with an ulterior motive, such as to influence or impress the speaker, will probably use the spare capacity to think about his "next move" in the conversation -- his rebuttal or what he will say next when the speaker is finished -- instead of focusing on understanding the speaker.

Strategy for overcoming this barrier

"Trying to influence or impress" is a difficult barrier to overcome, because motives usually can't just be willed away. Deciding not to have a motive usually only drives it beneath your awareness so that it becomes a hidden motive.

One strategy is to make note of your internal motives while you're listening. Simply by noticing your motives, any ulterior motives will eventually unravel, allowing you to let go and to listen just for the sake of listening.

That strategy comes from Vipassana meditation, where Buddhists try to free themselves of inner motives without seeking explicitly to do so.

#5 - Reacting to red flag words

Words can provoke a reaction in the listener that wasn't necessarily what the speaker intended. When that happens the listener won't be able to hear or pay full attention to what the speaker is saying.

Red flag words or expressions trigger an unexpectedly strong association in the listener's mind, often because of the listener's private beliefs or experiences.

Technology is often seen as the driver of improved communications, but technology, in itself, creates noise and discord as much as it melds minds.

Good listeners have learned how to minimize the distraction caused by red flag words, but a red flag word will make almost any listener momentarily unable to hear with full attention.

An important point is that the speaker may not have actually meant the word in the way that the listener understood. However, the listener will be so distracted by the red flag that she will not notice what the speaker actually did mean to say.

Red flag words don't always provoke emotional reactions. Sometimes they just cause slight disagreements or misunderstandings. Whenever a listener finds himself disagreeing or reacting, he should be on the lookout for red flag words or expressions.

Strategy for overcoming this barrier

When a speaker uses a word or expression that triggers a reflexive association, you as a good listener can ask the speaker to confirm whether she meant to say what you think she said.

When you hear a word or expression that raises a red flag, try to stop the conversation, if possible, so that you don't miss anything that the speaker says. Then ask the speaker to clarify and explain the point in a different way.

#6 - Believing in language

One of the trickiest barriers is "believing in language" -- a misplaced trust in the precision of words.

Language is a guessing game. Speaker and listener use language to predict what each other is thinking. Meaning must always be actively negotiated.

It's a fallacy to think that a word's dictionary definition can be transmitted directly through using the word. An example of that fallacy is revealed in the statement, "I said it perfectly clearly, so why didn't you understand?". Of course, the naive assumption here is that words that are clear to one person are clear to another, as if the words themselves contained absolute meaning.

Words have a unique effect in the mind of each person, because each person's experience is unique. Those differences can be small, but the overall effect of the differences can become large enough to cause misunderstanding.

A worse problem is that words work by pointing at experiences shared by speaker and listener.

If the listener hasn't had the experience that the speaker is using the word to point at, then the word points at nothing. Worse still, the listener may quietly substitute a different experience to match the word.

Strategy for overcoming this barrier

You as a good listener ought to practice mistrusting the meaning of words. Ask the speaker supporting questions to cross-verify what the words mean to him.

Don't assume that words or expressions mean exactly the same to you as they do to the speaker. You can stop the speaker and question the meaning of a word. Doing that too often also becomes an impediment, of course, but if you suspect that the speaker's usage of the word might be slightly different, you ought to take time to explore that, before the difference leads to misunderstanding.

#7 - Mixing up the forest and the trees

A common saying refers to an inability "to see the forest for the trees". Sometimes people pay such close attention to detail, that they miss the overall meaning or context of a situation.

Some speakers are what we will call "trees" people. They prefer concrete, detailed explanations. They might explain a complex situation just by naming or describing its characteristics in no particular order.

Other speakers are "forest" people. When they have to explain complex situations, they prefer to begin by giving a sweeping, abstract bird's-eye view.

Good explanations usually involve both types, with the big-picture "forest" view providing context and overall meaning, and the specific "trees" view providing illuminating examples.

When trying to communicate complex information, the speaker needs to accurately shift between forest and trees in order to show how the details fit into the big picture. However, speakers often forget to use "turn indicators" to signal that they are shifting from one to another, which can cause confusion or misunderstanding for the listener.

Each style is prone to weaknesses in communication. For example, "trees" people often have trouble telling their listener which of the details are more important and how those details fit into the overall context. They can also fail to tell their listener that they are making a transition from one thought to another -- a problem that quickly shows up in their writing, as well.

"Forest" people, on the other hand, often baffle their listeners with obscure abstractions. They tend to prefer using concepts, but sometimes those concepts are so removed from the world of the senses that their listeners get lost.

"Trees" people commonly accuse "forest" people of going off on tangents or speaking in unwarranted generalities. "Forest" people commonly feel that "trees" people are too narrow and literal.

Strategy for overcoming this barrier

You as a good listener can explicitly ask the speaker for overall context or for specific exemplary details, as needed. You should cross-verify by asking the speaker how the trees fit together to form the forest. Having an accurate picture of how the details fit together is crucial to understanding the speaker's thoughts.

An important point to remember is that a "trees" speaker may become confused or irritated if you as the listener try to supply missing context, and a "forest" speaker may become impatient or annoyed if you try to supply missing examples.

A more effective approach is to encourage the speaker to supply missing context or examples by asking him open-ended questions.

Asking open-ended questions when listening is generally more effective than asking closed-ended ones.

For example, an open-ended question such as "Can you give me a concrete example of that?" is less likely to cause confusion or disagreement than a more closed-ended one such as "Would such-and-such be an example of what you're talking about?"

Some speakers may even fail to notice that a closed-ended question is actually a question. They may then disagree with what they thought was a statement of opinion, and that will cause distracting friction or confusion.

The strategy of asking open-ended questions, instead of closed-ended or leading questions, is an important overall component of good listening.

#8 - Over-splitting or over-lumping

People have different styles of organizing thoughts when explaining complex situations. Some people, "splitters", tend to pay more attention to how things are different. Other people, "lumpers", tend to look for how things are alike. Perhaps this is a matter of temperament.

If the speaker and listener are on opposite sides of the splitter-lumper spectrum, the different mental styles can cause confusion or lack of understanding.

A listener who is an over-splitter can inadvertently signal that he disagrees with the speaker over everything, even if he actually agrees with most of what the speaker says and only disagrees with a nuance or point of emphasis.

That can cause "noise" and interfere with the flow of conversation. Likewise, a listener who is an over-lumper can let crucial differences of opinion go unchallenged, which can lead to a serious misunderstanding later. The speaker will mistakenly assume that the listener has understood and agreed.

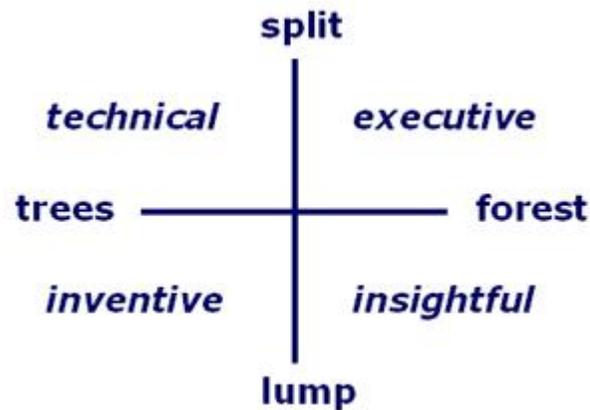
It's important to achieve a good balance between splitting (critical thinking) and lumping (metaphorical thinking). Even more important is for the listener to recognize when the speaker is splitting and when she is lumping.

Strategy for overcoming this barrier

An approach to overcoming this barrier when listening is to ask questions to determine more precisely where you agree or disagree with what the speaker is saying, and then to explicitly point that out, when appropriate.

For example, you might say, "I think we have differing views on several points here, but do we at least agree that ... ?" or "We agree with each other on most of this, but I think we have different views in the area of"

By actively voicing the points of convergence and divergence, the listener can create a more accurate mental model of the speaker's mind. That reduces the conversational noise that can arise when speaker and listener fail to realize how their minds are aligned or unaligned.



Quadrant of cognitive/explanatory styles

Often more than one barrier can be present at once. For example, a speaker might be an over-splitter who has trouble seeing the forest, while the listener is an over-lumper who can see only the forest and never the trees. Those two will have even more trouble communicating if one or both has the habit of "knowing the answer" or "treating discussion as competition".

Good listening is arguably one of the most important skills to have in today's complex world. Families need good listening to face complicated stresses together. Corporate employees need it to solve complex problems quickly and stay competitive. Students need it to understand complex issues in their fields. Much can be gained by improving listening skills.

When the question of how to improve communication comes up, most attention is paid to making people better speakers or writers (the "supply side" of the communication chain) rather than on making them better listeners or readers (the "demand side").

To a certain extent, listening is more crucial than speaking. An especially skillful listener will know how to overcome many of the deficiencies of a vague or disorganized speaker. On the other hand, it won't matter how eloquent or cogent a speaker is if the listener isn't paying attention.

The listener arguably bears more responsibility than the speaker does for the quality of communication.

Technology is often seen as the driver of improved communications. In terms of message transfer, technology certainly does play an essential role. However, communications is much more than just transferring messages. To truly communicate means to learn something about the interior of another person's mind.

Much has been said about the emergence of a "global mind" through technology. Of course, we've noticed that technology, in itself, creates noise and discord as much as it melds minds.

A deeper commitment to better listening is essential in order for technology to fulfill its promise of bringing the world together in real terms.

We can make a difference in the world by learning to listen better and by telling others about better listening. But only if they listen.

Appendix 22: Washington's Medicaid State Plan Amendment Services

1) Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

2) Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

3) Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

4) Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

5) “Freestanding Evaluation and Treatment” Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

6) Group Treatment Services: Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and

lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

7) High Intensity Treatment: Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

8) Individual Treatment Services: A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her

family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

9) Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

10) Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

11) Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

12) Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format

may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

13) Peer Support: Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumers ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

14) Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumers continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

15) Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

16) Special Population Evaluation: evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

17) Stabilization Services: Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.